

# D Neuro Amyotrophic Lateral Sclerosis Als

Record ID

## 1. Gold Standard Diagnosis

**Does the patient meet the diagnostic criteria for Amyotrophic Lateral Sclerosis (ALS) based on:**

(1) Progressive motor impairment documented by history or repeated clinical assessment, preceded by normal motor function;

- ☐ Yes  
☐ No  
☐ Not certain

(2) presence of UMN and LMN signs in at least 1 body region (with UMN and LMN dysfunction noted in the same body region if only one body region is involved) or LMN dysfunction in at least 2 body regions;

- ☐ Yes  
☐ No  
☐ Not certain

(3) investigations excluding other disease processes.

- ☐ Yes  
☐ No  
☐ Not certain

Does the patient meet the diagnostic criteria for Amyotrophic Lateral Sclerosis (ALS) based on the criteria above?

## 2. Type of ALS

Specify the type of ALS in the patient:

- ☐ Sporadic ALS  
☐ Familial ALS  
☐ Spinal/limb-onset ALS  
☐ Bulbar-onset ALS

If you selected "Familial ALS", please specify the genetic mutation if known:

## 3. Etiology

What is the suspected or known etiology of ALS in the patient?

- ☐ Genetic factors  
☐ Environmental factors

Genetic Factors

- ☐ C9orf72 mutation  
☐ SOD1 mutation  
☐ Other genetic factors

If you selected "Other genetic factors", please specify:

If you selected "Environmental factors", please specify:

#### 4. Clinical Presentation

Describe the clinical features and symptoms of ALS in the patient:

- ☐ Upper Motor Neuron Signs (e.g., spasticity, hyperreflexia)
- ☐ Lower Motor Neuron Signs (e.g., muscle weakness, atrophy, fasciculations)
- ☐ Bulbar Symptoms (e.g., dysarthria, dysphagia)
- ☐ Respiratory Involvement

#### 5. Disease Progression

Please provide information on the current stage and progression of ALS:

- ☐ Early Stage
- ☐ Intermediate Stage
- ☐ Advanced Stage

#### 6. Neurological Assessment

**Please provide results from relevant neurological assessments:**

Revised ALS Functional Rating Scale (ALSFRS-R) score:

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Forced Vital Capacity (FVC) percentage (if measured):

\_\_\_\_\_

Other neurological assessment (please specify):

\_\_\_\_\_

#### 7. Imaging and Diagnostic Tests

Electromyography (EMG) and Nerve Conduction Studies (NCS):

\_\_\_\_\_

Magnetic Resonance Imaging (MRI) of the brain and spinal cord:

Lumbar Puncture (if performed, specify findings):

\_\_\_\_\_

Genetic testing (if applicable, specify results):

\_\_\_\_\_

Other diagnostic tests (please specify):

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#### 8. Treatment and Management

Has the patient undergone any treatment or interventions for ALS?

- ☐ Yes
- ☐ No

Yes

- ☐ Medications
- ☐ Supportive Care

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Medications (if applicable):	<input type="checkbox"/> Riluzole <input type="checkbox"/> Edaravone <input type="checkbox"/> Sodium phenylbutyrate/taurursodiol <input type="checkbox"/> Tofersen <input type="checkbox"/> Symptomatic treatment (e.g., for spasticity, pain) <input type="checkbox"/> Other
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If you selected "Other", please specify:

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Supportive Care:	<input type="checkbox"/> Physical therapy <input type="checkbox"/> Occupational therapy <input type="checkbox"/> Speech therapy <input type="checkbox"/> Respiratory support (e.g., non-invasive ventilation) <input type="checkbox"/> Nutrition and swallowing support <input type="checkbox"/> Psychotherapy <input type="checkbox"/> Other
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If you selected "Other", please specify:

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